July 1, 2007 – June 30, 2008

Benefit	CareFirst BlueCross BlueShield Preferred Provider Organization	
	In-Network	**Out-Of-Network**
Deductible	$250 Individual/$500 Family	$500 Individual/$1,000 Family
Out-of-Pocket Maximum	None	$2,000 Individual/$4,000 Family
PHYSICIAN SERVICES		
Surgeon	100% AB after deductible	Covered at 80% of AB after deductible
In-Hospital	100% AB after deductible	80% AB after deductible
HOSPITAL		
Hospital Room/Semi Private*	100% AB after deductible/365 days	80% of AB after deductible/365 days
Outpatient surgery**	100% AB after deductible	80% of AB after deductible
Emergency Care (within 72 hours) • Facility • Facility/Practitioner • Provider's Office	 100% AB after $35 copay 100% AB after $20 copay 100% AB after $20 copay	 100% AB after $35 copay 100% AB after $20 copay 100% AB after $20 copay
MEDICAL SERVICES		
Diagnostic X-rays	100% AB, no deductible	80% AB, in office after deductible
Radiation & Chemotherapy	100% AB after $35 facility Copay and $20 physician Copay	80% AB after deductible
Laboratory Tests	100% AB, no deductible	80% AB after deductible
Allergy Testing	100% AB after $20 Copay	80% AB after deductible
Allergy Treatment/Injections	100% AB after $20 Copay	80% AB after deductible
Physical Therapy	$20 office Copay; $35 outpatient facility copay; $20 professional copay. 100 visit limit	80% AB after deductible 100 visit limit per benefit period;
PREVENTIVE CARE		
Well Baby & Child Care	100% AB after $20 Copay (no deductible)	80% AB (waive deductible)
Immunization	100% AB (no deductible)	80% AB (waive deductible)
Annual Physical Exam	One per calendar year age 18+; $20 Copay; 100% AB up to $200 maximum includes routine diagnostic tests (no deductible)	One per calendar year age 18+; 80% AB, $200 maximum includes diagnostic tests (after deductible)
Annual Gynecological Exam	One per calendar year $20 Copay; 100% AB (no deductible)	One per calendar year 80% AB after deductible
Eye Exams	No benefit for routine exam	No benefit for routine exam
Eye Glasses	No benefit	No benefit
OFFICE		
Medical Visits for Illnesses	100% AB after $20 Copay per visit; (no deductible)	80% AB after deductible

	In-Network	Out-Of-Network
SPECIAL SERVICES		
Hearing aid evaluation test (one every 36 months)	100% AB, no deductible	80% AB after deductible
Hearing aids (one every 36 months)	100% AB, no deductible	80% AB after deductible
Home Health Care Visits	90 days of unlimited visits covered at 100% AB; no deductible (approved plan treatment required)	90 days of unlimited visits covered at 100% AB; no deductible (approved plan treatment required)
Maternity Care	100% AB after deductible	80% AB after deductible
Infertility services Artificial Insemination & In Vitro Fertilization	Not covered	Not covered
Ambulance (when medically necessary)	100% AB no deductible	100% AB no deductible
MENTAL HEALTH/SUBSTANCE ABUSE COMBINED		
Inpatient Care*	Inpatient Hospital: 100% AB (no deductible) Halfway House: 100% AB (no deductible)	Inpatient Hospital: 80% AB (no deductible) Halfway House: 80% AB (no deductible)
Outpatient Care (services must be preauthorized)	Visits 1-5, 80% AB no deductible Visits 6-30, 65% AB no deductible Visits 31+, 50% AB no deductible	Visits 1-5, 80% AB after deductible Visits 6-30, 65% AB after deductible Visits 31+, 50% AB after deductible
PRESCRIPTION DRUG PROGRAM		
	$10 Copay – generic drugs $20 Copay – brand-name preferred drugs $35 Copay – non-preferred drugs Maintenance drugs: Retail – 3 Copays Mail Order – 2 Copays	$10 Copay – generic drugs $20 Copay – brand-name preferred drugs $35 Copay – non-preferred drugs Maintenance drugs: Retail – 3 Copays Mail Order – 2 Copays

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Health Benefits Certificate, the Group Benefit Guide or the Group Service Agreement.

AB-Allowed Benefit.

**Inpatient stays require precertification. ***If the hospital bills for use of the facility or provider bills for use of his office, the member will be subject to the appropriate copays.*